



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

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## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

HEALTHTRUST LLC  
PO BOX 890008  
HOUSTON TEXAS 77289

#### **Respondent Name**

Texas Mutual Insurance Company

#### **Carrier's Austin Representative**

Box Number 54

#### **MFDR Tracking Number**

M4-13-0945-01

#### **MFDR Date Received**

December 13, 2012

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "There were some extent issues listed on the preauthorization but none that were relate to the accepted compensable body part. However, due to the nature of our treatment, the carrier decided that the psychological component of the work injury was not related to the physical injury. Therefore he chose to deny these claims based upon that assumption. HealthTrust pursued both a BRC and then a CCH and at that hearing the office did choose to include the psychological component in the accepted compensable claim. He noted that 'the claimant's compensable injury of March 3, 2011, extends to and includes anxiety.'"

**Amount in Dispute:** \$890.24

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "The requestor submitted requests for reconsideration (rfr) of code 90806 for dates 8/22/11, 8/24/11, 8/29/11, and 9/6/11. Because these were received pas the submission timeline for such requests, Texas Mutual declined to issue payment. The requestor also submitted an rfr for code 96102, date of service 12.5.11. This too was untimely submission and Texas Mutual declined to issue payment."

**Response Submitted by:** Texas Mutual Insurance Company

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 22, 2011 through December 5, 2011	90806 and 96102	\$890.24	\$0.00

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.

2. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated

- CAC-219 – Based on extent of injury (Note: to be used for Workers' Compensation only)
- 246 – The treatment/service has been determined to be unrelated to the extent of injury. Final adjudication has not taken place
- CAC-138 – Appeal procedures not followed or time limits not met
- CAC-18 – Duplicate claim/service
- 878 – Appeal (request for reconsideration) previously processed. Refer to rule 133.250(H)
- 879 – Rule 133.250(B) – Health care provider shall submit the request for reconsideration no later than 10 months from the date of service

### **Issue**

1. Did the requestor waive the right to medical fee dispute resolution?

### **Findings**

28 Texas Administrative Code §133.307 states in pertinent part, "(c) Requests. Requests for MFDR shall be filed in the form and manner prescribed by the division. Requestors shall file two legible copies of the request with the division. (1) Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute. (B) A request may be filed later than one year after the date(s) of service if: (i) a related compensability, extent of injury, or liability dispute under Labor Code Chapter 410 has been filed, the medical fee dispute shall be filed not later than 60 days after the date the requestor receives the final decision, inclusive of all appeals, on compensability, extent of injury, or liability..."

The dates of service in dispute are August 22, 2011 through December 5, 2011. The final decision, inclusive of all appeals, on compensability, extent of injury or liability was issued by the Division on September 24, 2012. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on December 13, 2012. This date is later than 60 days after the date the requestor received the final decision on compensability, extent of injury, or liability. The Division concludes that the requestor has failed to timely file this dispute with the Division's MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

### **Conclusion**

The Division finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute. For that reason, the merits of the issues raised by both parties to this dispute have not been addressed.

### **Authorized Signature**

_____	_____	October 4, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

### **YOUR RIGHT TO APPEAL**

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**